Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 16, 2017

Ms. Wanda Waugh, Manager
Canterbury Inn
46 Cherry Street
Saint Johnsbury, VT 05819-2290

Dear Ms. Waugh:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on September 13, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

OCT 09 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0119	A. BUILDING: _____ B. WING _____	C 09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY INN	46 CHERRY STREET SAINT JOHNSBURY, VT 05819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensing survey, complaint investigation, and self-reported incident investigation were conducted by the Division of Licensing and Protection from 9/11 to 9/13/17. The following are regulatory findings.	R100		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the home failed to ensure that medication and treatment services were consistent with the physician orders for 1 of 6 residents sampled (Resident #1). Findings include: Per record review, Resident #1 has a history of agitated behaviors, and the physician prescribed a PRN (as needed) antipsychotic medication "Haloperidol 1 mg. at bedtime for agitation". Per the medication delegated staff, this PRN antipsychotic was only to be given to the resident after calling the Registered Nurse to describe the situation and obtain permission to give the psychoactive medication. Per record review of the administration record, the medication was given to the resident on the morning of 8/10/17 at 6:45 AM by one of the unlicensed medication staff. There was no evidence that the RN was consulted, and it was given outside the time	R128	POC accepted for all deficiencies Karen Campos 10/16/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Owner — (X6) DATE: 10/4/17

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R128	Continued From page 1 range of the physician's order. Per interview on 9/13/17, by telephone, the home's manager and RN confirmed that s/he had not been consulted on the morning of 8/10/17 regarding the administration of the medication, and that it was outside the prescribed time range.	R128		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that the written plan of care reflected the abilities and needs, or described care and services necessary for 2 of 6 residents sampled (Residents # 1 and #5). * This is a repeat deficiency from last two re-licensing surveys conducted on 10/22/13 and 6/30/15. Findings include: 1. Per record review of Resident #1, there are diagnoses that include dementia with behaviors, and documentation that s/he was sometimes sexually inappropriate with staff, and potentially with other residents. Per review of the plan of care, there was no mention of the need to watch the resident for sexually inappropriate behaviors,	R145		

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R145	Continued From page 2 although it was identified as an issue from the staff documentation and staff interview. The resident is prescribed an antipsychotic medication. Per review of the plan of care, there is no area to address the behaviors that are being documented nor the use of an antipsychotic medication. 2. Per record review of Resident #5, this resident has diagnoses that include Diabetes and elopement behaviors. Per review of the plan of care, there is no mention of the medical diagnosis of Diabetes with interventions to address this, and also no mention of the risk of elopement despite their multiple attempts to leave the facility. Per interview on 9/13/17 at 1:00 PM, the home manager confirmed that the care plans were missing the above information for Residents #1 and #5 as currently written.	R145		
R168 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and ii. The designated staff to administer insulin to	R168		

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R168	Continued From page 3	R168		

the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and

iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to meet the follDwing conditions for unlicensed staff to be permitted to administer insulin for 2 of 6 sampled residents (Resident #2, #3).

i. The diabetic resident's conditiDn and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and

ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; Findings include:

1. Per closed record review, discharged Resident #2 had Diabetes that required the use of a long-lasting insulin as well as a sliding scale dosage that was administered 3 times daily and was based on the glucose readings at the time of the administration at meals.

2. Per record review, Resident #3 also has Diabetes that requires the use of a long acting Insulin and also a sliding scale dosing of short

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R168	Continued From page 4 acting insulin to be given at meals. The kitchen staff ask the resident what they are going to eat at a particular meal, and then calculate the carbohydrates they will eat. The physician wrote the sliding scale dosage chart based on the amount of carbohydrates eaten, and the staff adjusted the dose by this calculation. Per review of staff training documentation, there was no evidence presented that indicated the staff had been shown the proper techniques and demonstrated proficiency in this method of administering insulin to these residents. Per interview on 9/13/17 at 1:15 PM, the Registered Nurse of the home confirmed that the training that was provided to the staff was not documented as being completed.	R168		

Plan of Correction

R128V

SS=D Resident #1 's order for PRN Haldol was not an order that we use very often for this resident. I can only assume that the attendant doing meds just didn't realize that it was only supposed to be given at bedtime, as his behavior and agitation level was the same as it is on occasion in the evening. However, that is no excuse for not checking the order first. On 10/02/17 we had his Haldol order changed to: Haldol 1 mg. po q12 hrs PRN for agitation, which should create less confusion. Also as of 10/02/17, I have written on all of the psychotropic PRN med packs (which are actually only a few) and the orders in the MAR: "Notify RN before giving this medication." The medication, time, date, and notification of RN for permission to give the med, will be documented on the resident's chart for each occurrence and for each incident.

It was unfortunate that this attendant made that mistake, as she knew well that I was to be called for these PRN meds. I am sure that if she had called me talk about what was happening, we would have realized what that order actually said. This staff person has been handling medications correctly for the past 12 years.

R128 PoC accepted KCampo

R145V

SS=D As of 10/02/17, Resident #! and Resident #5 have had their care plans updated to reflect the diagnoses of the resident, and the care that they need. As of 10/02/17, all care plans will be more aligned to reflect the resident's problem list and diagnoses. I will continue to monitor and update care plans on a monthly basis or as essentially needed.

R145 PoC accepted KCampo

R168V

SS=D Resident #2 is no longer at Canterbury Inn.

As of 10/02/17 all staff medication training will be documented with date, time, training content, staff name and RN signature. Sliding scales and use of Insulin pens will be a part of the medication orientation training and will be documented for each med- delegated staff member by the RN. I am also working on a written medication exam that all current med-delegated staff will take on a mandatory basis beginning 10/19/17 and will be incorporated into the medication orientation training for all future delegated staff.

R168 PoC accepted 10/16/17 KCampo

Wanda Draughn RN 10/4/17